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New Developments in Sexual Health and HIV/AIDS Policy

Government response to the Health
Select Committee's Third Report of
Session 2004–2005

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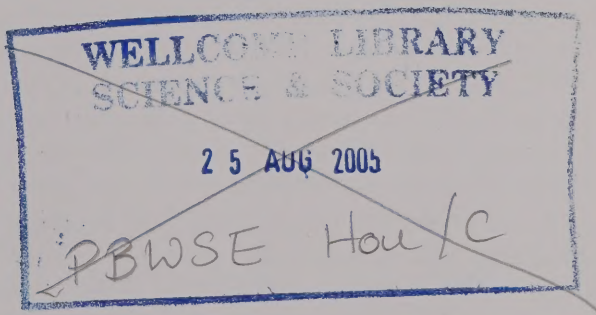
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Select Committee's Third Report of
Session 2004–2005 on New Developments
in Sexual Health and HIV/AIDS Policy



Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
July 2005

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Government response to the Health Select Committee's Third Report of Session 2004-05 on New Developments in Sexual Health and HIV/AIDS Policy

Introduction

1. This Command Paper sets out the Government's response to the Health Select Committee's Third Report of the Session 2004/5 on New Developments in Sexual Health and HIV/AIDS Policy.

Sexual Health

2. From 2001 there have been a number of steps/events which have shaped progress on sexual health and helped to ensure that it is given a higher priority. First, the launch of the *National Strategy for Sexual Health and HIV* in late 2001. Second, the launch of a number of good practice guidance and supporting materials during 2002 and 2003. Third, the formation of the Independent Advisory Committee on Sexual Health and HIV in April 2003. Fourth, in July 2003, a report by the Health Select Committee which raised many concerns about sexual health, followed by the Government's reply in November 2003 in which extra funding was announced for Genito Urinary Medicine (GUM) services, improved chlamydia testing and contraceptive services. Fifth, the publication of the NHS Priorities and Planning Framework in July 2004 and the new Public Service Agreement (PSA) target which broadened the teenage pregnancy PSA to include a goal to improve wider sexual health. And finally, sixth, the public health White Paper, *Choosing Health* published in November 2004. This headlined sexual health as a priority area for action, announced an extra £300m to help achieve this and introduced sexual health strongly into local delivery plans. A National Support Team will be created to address poor performance and support delivery and co-ordinate the spread of good practice nationally, regionally and locally. All these factors mean that the Government is determined to bring about significant improvements in the nation's sexual health.

3. We are already beginning to see reductions in the transmission of some sexually transmitted infections (STIs) while rates of increase for other infections are slowing, together with some improvement in average waiting times at GUM clinics. Most significantly, now that sexual health has featured as one of the key priority areas in the public health White Paper, *Choosing Health*, backed by significant new funding and improved performance management, the Government expects to see further improvements over the next few years. This is a new era for sexual health, with the Government driving forward the agenda to modernise sexual health services and transform attitudes to safer sex. The aims are many fold, but principally they are to reduce STIs, improve reproductive health, educate the public and deliver better quality services which are more patient centred.
4. New Government investment of an additional £300 million over 3 years was announced by the Secretary of State for Health in December 2004. This new money, coupled with the new performance management system for sexual health, is now starting to reach front line services to drive delivery. We are working closely with Strategic Health Authorities (SHAs) to monitor progress so that we can be confident that the challenging targets on GUM access will be achieved right across the country by March 2008.
5. The Government shares many of the Committee's views on sexual health and recognises the need to fulfil both the demand for better access to higher quality services now, coupled with increased prevention efforts to reduce future demand. Of the £300 million White Paper funding, £130 million will be allocated specifically to tackle long waiting times and push forward service modernisation in GUM. In addition, we are pleased to be able to announce a further £15 million new capital funding this financial year to help maintain momentum in making improvements to the GUM estate.
6. The Government is also aware that contraceptive services are in need of resources and increased priority, and a separate sum of £40 million has been identified from the £300 million to address gaps in service provision. This will be informed by a comprehensive national contraceptive audit so that we can be sure that we are clear, both locally and nationally, exactly how to best modernise this important part of sexual health services, where we know that for every £1 spent there will be offsetting savings of at least £11, due to reduced risks of STI transmission, and unintended pregnancies.
7. Despite recent improvements, high rates of STIs continue to cause concern, and £50 million will be used to develop and implement a new high profile national sexual health media campaign to raise awareness of the risks of unprotected sex. This will link to the existing teenage pregnancy campaign and targeted sexual health promotion work for groups most at risk.

8. The Government is also determined to tackle the concerns raised about the most common STI, chlamydia. We are working to accelerate the roll-out of the National Chlamydia Screening Programme so that it will cover the whole country by March 2007. This is much earlier than originally anticipated, and is possible due to the additional investment of £80 million arising from the White Paper. A further £8 million has been allocated to ensure that laboratories are equipped to use the preferred Nucleic Acid Amplification (NAA) test for chlamydia, which is non-invasive and produces the most reliable results.
9. All of these initiatives are taking place against the backdrop of a restructured NHS and a shift towards devolved resources and policy making. To help ensure sexual health is high on the list of local priorities and that new investment is spent effectively, the Government has for the first time built sexual health fully in to the local delivery planning targets and all the improved performance management which goes with this. The Department of Health is working with SHAs to make sure these plans really will deliver improvements on the front line. Sexual health is now included in Primary Care Trusts' (PCTs') Local Delivery Plans (LDPs), which will help ensure that sexual health is prioritised at local level and that the funding is not diverted to other areas. The specific activity indicators to be included in LDPs are, in summary:
 - The percentage of patients attending GUM clinics who are offered an appointment to be seen within 48 hours of contacting a service, aiming to reach 100% by 2008. SHAs are advised that they may also find data on contraception use and services helpful and that a national audit of these services will take place. The structure of this LDP line relates to the target set in the White Paper for 48 hours access to GUM clinic services. The introduction of this 48 hour target is intended to bring access to public health services in line with access to other primary care access services.
 - The number of new diagnosis of gonorrhoea per 100,000 population. Gonorrhoea incident rates provide a useful proxy measure for all STIs and HIV. SHAs may also wish to consider PCT level information on provision of effective contraception, as this can contribute directly towards reducing incidence of STIs.
 - The percentage of the sexually active population aged 15-24 accepting screening for chlamydia (from April 2006). Criteria for SHA sign-off of plans highlights that 50% of the sexually active population accepting screening for chlamydia each year is achievable. This LDP line was included following the publication of the White Paper to ensure the new sexual health campaign was given the appropriate priority by the NHS.

10. In addition, the Department of Health's document *National Standards, Local Action: Health and Social Care Standards and Planning Framework* (2004) clearly reflects the importance of sexual health. This document includes the national target, set out in the Department of Health's public service agreement "to reduce the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health". It also signposts the public health White Paper, and states that the NHS, together with Local Authorities, will need to take the White Paper into account when developing their policies that will contribute to the delivery of the national target. The document also highlights the sexual health areas which will be particularly relevant for PCTs and their local authority partners to cover in their plans, including STI rates, access times and contraceptive and sexual health service provision.
11. Another measure to raise the priority of sexual health, and improve the quality of services is the publication of recommended standards. The Department commissioned *Recommended Standards for NHS HIV Services* which were produced by the Medical Foundation for AIDS and Sexual Health (MedFASH), the British HIV Association (BHIVA) and the National Association of NHS Providers of AIDS Care and Treatment (PACT) in 2003. These were followed earlier this year by the publication of *Recommended Standards for Sexual Health Services*, produced by MedFASH. Both documents were produced in consultation with a wide range of stakeholders and are designed to give PCTs and commissioners best practice guidance on a range of service provision, based on evidence.
12. In taking forward its sexual health strategy, the Government recognises the importance of improved access to good quality training across all relevant parts of the workforce. To this end, work has continued on producing a training action plan (2004). Most recently, the Department has worked with its National Sexual Health Training Group to publish *Quality standards for sexual health training* (2005). These will support the implementation of the public health White Paper, which identified training and workforce capacity issues as integral to the sexual health agenda.
13. On HIV prevention, DH continues to support comprehensive programmes of targeted work for gay men and Africans through contracts with the Terrence Higgins Trust and the African HIV Policy Network. The success of offering and recommending an HIV test to every pregnant woman has resulted in a dramatic fall in the number of women giving birth to HIV positive babies. Detection of HIV in pregnant women has prevented the transmission of HIV to 180 babies in 2003. The early introduction of harm reduction facilities such as needle exchange schemes has resulted in HIV prevalence remaining low (1%) among injecting drug users. All work addressing the aims and objectives of the National Strategy for Sexual Health & HIV is underpinned by a world class surveillance system at the Health Protection Agency (HPA), that provides detailed data on HIV prevalence both at national, regional and PCT level. The goal of providing high quality services for people with HIV, wherever they live in England has been enhanced by the publication of "Recommended Standards for NHS HIV Services".

14. Throughout the process of implementing its strategy, the Government is continuing to work closely with experts in the field and a wide range of stakeholders on matters relating to sexual health policy, and the Department of Health is indebted to the Government's Independent Advisory Groups and the numerous voluntary sector organisations and service users who provide valuable input.

Charges for overseas visitors for HIV treatment.

15. It is worth beginning by reiterating the basic rules around access to free NHS hospital treatment by overseas visitors. An overseas visitor, in this context, is defined in the NHS (Charges to Overseas Visitors) Regulations 1989, as amended ("the charging regulations"), as anyone who is not ordinarily resident in the U.K. The House of Lords, when interpreting the phrase "ordinarily resident" in 1982, made clear that it is not enough just to be living in this country for a reasonable length of time and for a specific purpose: one must also be living here lawfully if the ordinarily resident criteria are to be met. Thus no one who is staying here illegally, for whatever reason, should be considered ordinarily resident for NHS purposes, no matter how long they have been here. The Government is clear that this is an entirely appropriate approach – no one here illegally should be able to take advantage of the NHS just because they have managed to stay here for a long time.
16. The charging regulations specify that all overseas visitors are chargeable for NHS hospital treatment unless they meet one of a wide range of exemption criteria set out in the Regulations. These include, for example, people coming here legitimately to work for a UK based employer, students on courses of at least 6 months' duration and asylum seekers. There are also some treatments that are in themselves exempt from charges, so that they are free to all, regardless of residential status. This includes the treatment of TB, and the initial diagnostic testing for HIV and associated counselling. Subsequent treatment should the test prove positive, is not and never has been free to chargeable overseas visitors. None of the changes introduced in April 2004 had any effect on this underlying principle, and it is factually incorrect to suggest otherwise, as some of the evidence presented to the Select Committee appears to have done, and as the Committee itself seems to believe.
17. The 2004 changes did, however, have an effect in two specific areas. Firstly, as the Select Committee's report indicates, changes were made to the exemption category relating to length of stay in the UK. It had always been the intention that this exemption should only apply to those who had been in the country legally for at least 12 months, otherwise this exemption defeated the object of the ordinarily resident test. However, because what is now Regulation 4(1)(b) did not specifically say so, it was open to abuse by anyone who had managed to remain in the UK for 12 months, even if they were here illegally. The wording was therefore amended so that the element of lawful residence was completely transparent. It is worth emphasising that this change was made, not in order to make it more difficult for HIV patients to get free treatment, but in order to stop abuse of the NHS as a whole by people here illegally.

18. The second effect of the 2004 changes, and the publicity surrounding them, was to raise awareness, not just of the changes but also of the existing rules. In other words, the NHS is beginning to get better at fulfilling its legal obligation to ensure that it provides free hospital treatment only to those who are eligible to receive it. This applies equally to the rules around HIV treatment as to any other NHS hospital treatment. Moreover, it would seem that the message is also beginning to get out to patients and the public that if they have come from overseas, they should not assume that they will get free hospital treatment.
19. The Government is grateful to the Committee for continuing to highlight its concerns about the practical implications of its policies and those areas where further work is needed. Below, is the Government's detailed response to each of these recommendations.

CONCLUSIONS AND RECOMMENDATIONS

DEVELOPMENTS IN SEXUAL HEALTH

Improving sexual health services: resources and capacity

1. We are concerned that it took at least seven weeks for the Deputy Head of the Sexual Health Policy Branch at the Department of Health to realise that the Department had been sent key data on sexual health which it had commissioned, and that the responsible Minister had not seen this data in advance of her appearance before the Committee. We are also surprised by the air of secrecy which surrounds this research, and can only surmise from this that it contains findings that would be unwelcome for the Government. If the Government places any value on the scrutiny work of Parliament, and takes seriously its commitment to co-operate with the work of Select Committees, it would seem counterproductive to withhold the most up-to-date information on sexual health services from the Health Committee when it is conducting an inquiry into precisely this subject. (Paragraph 14)

The early summary of findings from the DH funded GUM review have not been withheld from the Committee because they are unwelcome to the Government. The Government has for some time publicly recognised the urgent need to improve GUM services and have shown our commitment to this through increased investment and improved data collection and performance management. No secret has been made of the national GUM waiting times data collected and published on the Government's behalf by the Health Protection Agency. Rather, as was made clear to the Committee at the time of their request, we considered this very much a work in progress and at that time, Ministers had not had the opportunity to fully consider the findings. In general, when conducting such work, we believe it is better to publish material together when all quality assurance checks have been carried out, rather than to disseminate the information in a piecemeal fashion. Also, we had not made any commitment to publish data at such an early stage in the review. Nevertheless, the Government does value the work of the Committee and recognises its interest in this data. Having now had the opportunity to review the information, Ministers are content for it to be made available. A copy is, therefore, being provided to the Committee with this response.

- 2. We welcome the Government's adoption of our recommendation of a 48-hour access target for sexual health services. However, the Government should take note of the warnings we have been given by clinicians that this target may not be achieved within the timeframe specified by Government without additional spending, and that inadequate facilities may present a barrier to service expansion. (Paragraph 23)**

The public health white paper set out a commitment that by 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours. This goal is challenging, and quite rightly so if we are to see the dramatic improvements in sexual health that are needed. Primary Care Trusts (PCTs) and SHAs are required to plan how they will meet the goal of 48 hour GUM access by 2008, through their local delivery planning mechanism. The inclusion of sexual health in the teenage pregnancy PSA target will also help to ensure that the priority of sexual health is raised at local level and the necessary action is taken to improve access to services. The Government has recently announced very significant levels of new funding over the next 3 years to help meet this target – £130 million of the £300 million announced through the public health White Paper, in addition to the £42 million already invested to implement the *National Strategy for Sexual Health and HIV*. The Government therefore believes that PCTs now have the resources to make this happen, and will be monitoring progress carefully.

- 3. We also welcome the Government's adoption of our recommendation for a dedicated health education campaign aimed at improving sexual health. However, the Government should not begin the campaign until it is certain that services have the extra capacity they need to meet the extra demand the campaign will generate. (Paragraph 24)**

The Government understands concerns about service capacity and that a careful balance needs to be struck on the timing and content of the campaign to maximise overall effectiveness. We believe the first stage in improving sexual health should be to use strongly focused prevention messages, which will help to reduce the demand for sexual health services. In planning the campaign we recognise that many existing sexual health services will need time to deal with backlogs and begin the process of modernisation using the new investment. Only when the numbers of new cases begins to stabilise or decline, will we move forward to the second stage of the campaign – signposting people to screening and treatment – and this will happen gradually through local mechanisms, rather than national ones, to avoid the risk of generating a demand for services which simply cannot be met. The first goal of the campaign must be to normalise condom use in the context of an informed approach to safer sex, contraceptive choices and avoidance of STIs.

4. **We welcome the extra investment for GUM services of £130 million over three years, but evidence submitted to our previous inquiry into sexual health suggested that the true funding needs of GUM services may be far greater than this. Estimates provided by the Association of Genito-urinary Medicine suggested that around £150m of capital funding alone would be needed to modernize GUM facilities, and on top of this we were given evidence of the need for up to £30 million per year additional revenue funding for GUM services, giving a total of some £240 million. The Government should keep the funding of GUM services under close review and be prepared to increase allocations if this should prove necessary. (Paragraph 28)**

We consider that the £130 million investment for GUM services announced with the public health White Paper allocations is a major additional investment and demonstrates our commitment to improving access and modernising these services. This allocation spans both capital and revenue investment. In terms of capital funding, we have already allocated £15 million in 2004/5 which was targeted at those clinics most in need of modernisation. We are pleased to be able to announce a further £15 million new capital funding this financial year to maintain momentum in making improvements to the GUM estate. Ultimately, however, funding arrangements are a matter for the NHS and it is therefore PCTs who will need to keep the funding of all sexual health services (not just GUM) under review in the context of meeting the challenging targets which have now been set out for them.

5. **We welcome proposals to improve performance monitoring around sexual health. However, we remain very concerned by reports that previous allocations for GUM services, when filtered through PCTs, often did not reach the services for which they were intended, but were siphoned off to fund services identified by PCTs as being of a higher priority. To ensure that this does not happen again, we recommend that, at least for the next three years, the Department supplement its existing performance management of sexual health services by commissioning a specific financial audit to check that funding has reached its intended destination. The audit could be carried out by the Audit Commission or the Healthcare Commission. The results of the audit should be published to identify any funding gaps that may occur. (Paragraph 34)**

Sexual health must now be included in PCTs local delivery plans in the same way as any other NHS funding stream and we believe there is little benefit to be gained from introducing checks which may prove unnecessarily burdensome. The Department of Health has no plans to audit how the NHS spends its money but is keen to free PCTs to prioritise their local funding according to local needs, and serve the population as effectively as possible within a broader national framework.

The improved performance measures introduced through the public health white paper, will significantly strengthen the incentive for local investment and service modernisation. SHAs have submitted draft Local Delivery Plans to the Department of Health, which include plans to meet targets on reducing the incidence of gonorrhoea and 48 hour access to GUM services as well as a more detailed planning proforma covering the development of sexual health services by PCTs within the SHA concerned. We are pleased that these show that overall planned progress is on track to meet national targets and plans are recognising the national strategic importance of sexual health. They show, for example, that baseline mapping is taking place and that many areas are undertaking detailed local needs assessment. Trusts, such as those in South East London, are actively seeking user feedback on services through initiatives such as 'mystery shopper' programmes and focus group work with young people. Health Equity Audits are being used in some areas to assess, for example, access issues for vulnerable populations. Nevertheless, we understand the importance of ensuring that these plans are robust and lead to real improved outcomes. Therefore, where plans have lacked detail on investment, SHAs have been asked to provide further information or, in some cases, resubmit plans where progress was not in line with national expectations.

6. The Department, in its response to this Report, should also supply us with a detailed breakdown of the £300 million funding for sexual health services, specifying whether the funding is entirely new, or is part of the total funding for PCTs already announced, as implied by the Minister. (Paragraph 35)

This new funding is largely part of PCTs new allocations and is additional to what they would otherwise have received. A breakdown of the £300 million funding for sexual health was set out at paragraph 24 of the Memorandum of evidence submitted to the Committee by the Department of Health¹, and is summarised as follows:

New sexual health campaign	£50m over 3 years
Modernisation of GUM services	£130m over 3 years (capital and revenue)
Acceleration of the National Chlamydia Screening	£80m to March 2007
Investment to improve contraception Services (and national audit)	£40m over – £20m in each of 06/07 and 07/08

With the exception of £50 million for the national sexual health campaign, the majority of this funding is being allocated directly to PCTs and it is for individual PCTs to decide how they allocate these resources according to their local population needs. £130 million for sexual health modernisation includes funding for improving access to GUM, contraceptive services and a small amount for abortion services. In terms of GUM, part of this £130 million is capital investment to improve premises, and the best process for allocating this funding is currently being considered.

Chlamydia screening

7. **Both men and women should be screened for chlamydia. We are concerned that current efforts to screen men are insufficient. Furthermore, by introducing the cut-off for the screening programme at 25 year-olds the Government also risks missing a significant proportion of young people who remain vulnerable to chlamydia infection and its consequences. We therefore recommend that the national chlamydia screening programme be extended to men as well as women, and that the target age range be extended from 16 – 25 year olds to 16 – 29 year olds, at least initially. If it is subsequently shown that chlamydia screening is beneficial across a wider age range than this, the Government should extend the programme accordingly. (Paragraph 43)**

See below

8. **In addition, we note that there are limits to what can be achieved by an opportunistic screening programme, which relies on people seeking out healthcare services for another reason, such as contraception, rather than proactively inviting them to attend for a test. This may pose particular problems in screening young men, as research suggests that young men generally attend health services less frequently than women. We therefore recommend that the Government monitors the rates of chlamydia infection closely to assess the effect of the national screening programme, and that, if rates of chlamydia continue to increase, it considers supplementing the opportunistic screening programme with a proactive call-and-recall system targeting specific high-risk groups. (Paragraph 44)**

The National Chlamydia Screening Programme (NCSP) has been developed in line with the recommendations of the Chief Medical Officer's Expert Advisory Group, which recommended screening take place for individuals at high risk of chlamydia infection. In England, these are young women aged 16 to 19 and young men aged 20 to 24. People outside of these age groups, who consider themselves at risk, can attend sexual health services for testing and treatment in the usual way, and the forthcoming sexual health media campaign will help to raise awareness of chlamydia across a wider age range.

A recent meta-analysis of chlamydia prevalence studies in the UK confirmed that those under 25 years of age were the most likely to be infected. Behavioural and biological factors contribute to the increased risk within the younger adult population, as they tend to have more frequent changes in sexual partners, and for young women cervical ectopy (which increases susceptibility through proliferation of epithelial cells) is common. All UK screening programmes are targeted in terms of age and we consider that it is appropriate to continue to target those age groups most at risk to most effectively control prevalence and ensure cost-effectiveness. Research into the impact of systematic opportunistic screening of asymptomatic populations has shown that targeting young people, who are most at risk, also leads to reductions in prevalence among those not targeted.

The NCSP is the first nationally co-ordinated programme of its type in Europe and, unlike screening programmes in other countries, we do target young men for chlamydia screening as well as women. We recognise that there are particular challenges in encouraging young men to access chlamydia screening as they do not attend health services as regularly as young women. However, recent analysis of attending behaviour by young people in the NHS showed 69% of men under 25 years of age and 90% of women in the same age group had been to their GP in the last 12 months. The challenge is to make the most of the “opportunity” of these attendances and encourage all providers to take the few minutes and offer chlamydia screening to this vulnerable population. Screening is already being offered in places such as colleges, sports facilities, workplaces etc., and the forthcoming pilots of chlamydia screening in pharmacies, will provide additional routes through which young men can access screening. In addition, male partners (of whatever age) of women with chlamydia are targeted through partner notification, which is an integral part of the programme.

Before the roll-out of the programme began, the feasibility of our approach was confirmed through a study at 2 sites in England (Portsmouth and the Wirral). The programme has been informed throughout its continuing development by research, modelling and evaluation. New research evidence is reviewed by the National Chlamydia Screening Steering Group (NCSSG) to inform the ongoing development of the programme.

We agree that postal invitation and a “call/recall approach” can be part of a series of screening offers to achieve the greatest coverage of populations at risk. However, the international evidence does show that, given time and investment, opportunistic screening programmes do work and are cost effective.² It is important not to lose sight of the need for high levels of screening over at least a 3 year period to see an impact on the prevalence of infection in the population. The NCSP has just begun and it is still in the process of being rolled-out across the country. We must also remember that any “call/recall” or direct targeting of young people for screening through mail invitations or from patient registers, needs to appropriately select those persons who are sexually active, as it is only through sexual intercourse that genital chlamydial infection is transmitted. Because of the inherent difficulties in this, the Chief Medical Officer did not recommend this approach in the first instance.

2 Establishing the National Chlamydia Screening Programme in England: results from the first full year of screening. D S LaMontagne et al. November 2004.

Published data from the NCSP to date shows that testing and treating can successfully be offered in a variety of settings. A recent paper by Macleod et al. in the British Medical Journal showed that while systematic chlamydia screening by single postal invitation is feasible in England, this had limited impact as highest uptake was in young, middle class females and the lowest was in areas with high numbers of ethnic minority residents and in areas of high deprivation. Additionally, no study of postal screening has operated for more than a one-off, and thus it remains unknown whether this strategy is sustainable over the 3-5 years needed to impact on disease prevalence. We will continue to work with local programme areas to evaluate which screening strategies work most effectively in terms of achieving maximum coverage for the programme.

The first annual report of the programme for 2003/4³ considered the progress made to date and highlighted the challenges facing the programme and how these are being addressed. The roll-out of the NCSP is being boosted by an additional £80 million investment in order to ensure coverage across the whole of England by March 2007. From April 2006, chlamydia screening is included in PCT's local delivery plans with performance management at SHA level. Plans should demonstrate how PCTs will work towards screening 50% of sexually active young people for chlamydia annually (from April 2006).

9. **It is unacceptable that a test is still being used for chlamydia which may miss as many as 30% of infections, when a far more accurate test is available. We are pleased that the Government is to make NAA testing available in all areas, but disappointed that this will not happen until 2007. Some clinicians even doubt that this target can be achieved. The Government will need to monitor this target carefully over the next two years to ensure that NAA testing is, indeed, universally available in all clinical settings by 2007. (Paragraph 48)**

The Government has recognised that the need to switch to the optimal NAA test should be treated as a priority. To this end, £7 million pump-priming money was invested in 2004/5 to ensure that all major laboratories in each region of England use the most effective technology and a further £1 million in 2005/6 to complete this process. The Chief Medical Officer wrote to SHAs in 2003 highlighting the arguments for converting to NAA testing and the funding available to implement this change. NAA testing will be available in these areas later this year. The use of NAA testing is a mandatory requirement of the National Chlamydia Screening Programme and will, therefore, be in place across the whole country by March 2007. The Department is liaising closely with the Purchasing and Supply Agency (PASA), who are co-ordinating the tendering and procurement process of acquiring NAA testing and negotiating contracts with suppliers, as well as SHAs, to monitor progress.

3 The first steps...Annual report of the National Chlamydia Screening Programme in England, 2003/4. Dept of Health. 2004.

Sexual health and primary care

- 10. We are disappointed that the Minister does not appear to share the view of many leading authorities in the area of sexual health that primary care services are a huge untapped resource for delivering sexual health services, and crucial to improving the nation's sexual health. Indeed, the Government's own Strategy on Sexual Health and HIV set out a key role for GPs. While we do not want to downplay the potential role of community pharmacies, it is clear they are unable to provide the same level of service as a GP or a specialist sexual health clinic. Moreover, most community pharmacies are not yet in a position to be able to offer sexual health services. By contrast, most of the population is registered with a GP, and GPs currently provide 80% of contraceptive services. Consequently, GPs are uniquely well placed to offer opportunistic screening or health promotion advice in the area of sexual health. (Paragraph 58)**

See below

- 11. The initial negotiations over the GP contract were a wasted opportunity to mobilise GPs to tackle sexual health. We are therefore pleased to hear from the Department of Health official that a formal review of the GMS contract will take place. We recommend that the Government and the BMA review the contract as soon as possible. We further strongly recommend that the Government negotiates for the inclusion of sexual health services within the "Essential Services" or "Additional Services" headings of the contract, with the introduction of quality points to encourage GPs to provide these services. (Paragraph 60)**

See below

- 12. We are pleased that the Department recognises the advantages of GPs undertaking chlamydia screening. We recommend that the Department makes provision for such screening when it reviews the GP contract. (Paragraph 63)**

The Government fully recognises the vital role that GPs and other primary medical services contractors can play in delivering sexual health services – and this is something which we actively wish to develop as set out in the *National Strategy for Sexual Health and HIV*.

A review of Primary Medical Care contractual arrangements (including General Medical Services – GMS) is currently underway. Specific issues, such as contraception and chlamydia screening, will be actively considered in relation to maximising the opportunities for improving the quality of sexual health service delivery in general practice and across primary medical services. No final decisions have been made on where chlamydia screening and testing might be best incentivised with the current contractual arrangements. The Department of Health has submitted a proposal to the independent Expert Review Team considering evidence for amending the Quality and Outcomes Framework (QOF). Another option might be to develop a suitable service specification that PCTs could utilise through Enhanced Service arrangements. Sexual health services also lend themselves to the flexible opportunities now available through the other primary medical care contracting routes introduced in April 2004, which give PCTs the ability to contract for these services using alternative providers such as the private, voluntary or other public sector organisations. We understand that some PCTs are exploring this option. (See also recommendation 16 below).

Workforce and training

- 13. In our previous inquiry, serious concerns were raised about shortages of consultants who specialise in sexual health. Our evidence suggests that the situation is little improved since then and that it may be necessary to provide sufficient consultants to deal with an expected increase in GUM patients of between 30-50% before 2008. We recommend that the Government takes account of this in its workforce planning. (Paragraph 67)**

We recognise that addressing workforce issues is integral to increasing capacity and improving access to sexual health services. Over all the Government is increasing NHS staff numbers year on year through increased training; improving retention through improved pay and conditions; and attracting more workers back into the NHS. Since December 2003, the number of consultants working in the NHS has increased by 1,646 (5.6%) to 30,863 in December 2004. Also, between September 2003 and September 2004 the number of Registrar Group Doctors increased by 2,204 (15.1%). The numbers of hospital, public health medicine and community health services staff with a specialty in GUM in England have increased from 709 (458 full time equivalent (fte)) in 1997 to 906 (662fte) in 2004. Of these, 322 (298 fte) were consultants at December 2004. An increase from 239 (222 fte) in 1997. In addition to increasing consultant numbers, our strategic aim is to achieve greater diversity of sexual health service provision, which should help to relieve pressure on GUM consultants. This is being supported through measures such as the GUM service review, the audit of contraception services, and greater service provision outside of the GUM setting. These will help to identify and disseminate good practice and new ways of working. Innovative measures are being introduced in many areas to ease burdens on staff resources. For example, the use of new technologies to deliver some HIV test results at the Chelsea and Westminster GUM clinic is estimated to free up approximately 36 hours of staff time each week⁴.

4 Response to the Government White Paper – Choosing Health?. Independent Advisory Group on Sexual Health and HIV. 2004.

- 14. It is essential that GPs and practice nurses are properly trained and supported to provide sexual health services. We therefore recommend that the Government develops a sexual health training programme for primary care clinicians, possibly modelled on the successful training programme for the primary care management of substance abuse. This must be funded by a dedicated training budget. (Paragraph 68)**

Training and education are the bed-rock for delivering high quality sexual health services. There is a wide range of national and local courses, at varying levels, available for GPs to improve their knowledge and expand their skills in delivering sexual health services. Information on all courses relating to sexual and reproductive health is being compiled by the Genito-Urinary Nurses Association and is to be placed on their website. The Department of Health is leading a multi-professional group to devise a framework of the competencies required in primary care for delivering the More Specialised Sexual Health Services NES. Discussions are currently underway between the Royal College of General Practitioners and Department of Health around developing a sexual health training programme specifically for general practice.

Also, £200,000 has been allocated by the Department of Health to support nurses undertaking a distance learning programme. This will train 2,700 practice nurses in basic sexual health skills and the supply of condoms and emergency contraception.

Reproductive health

- 15. We recommend that the Government takes steps to promote and facilitate better joint working between GUM and family planning services, in order to move towards the integrated model of sexual health services set out in its *National Strategy for Sexual Health and HIV*. This should include addressing any potential difficulties which may arise through new funding and purchasing arrangements. (Paragraph 71)**

We are committed to working towards improved integration and joint working between GUM and community contraceptive services. As part of this process we have commissioned a comprehensive three year evaluation of One-Stop Shop Sexual Health Services by a joint team from University College London and Bristol University. The evaluation is looking at three models of One-Stop Shop sexual health services which provide advice, contraceptive and GUM services on a single site. These three models are:

- a dedicated young people's integrated GU and contraceptive service;
- a specialist primary care led service; and,
- a specialist service to meet the needs of all age groups.

The evaluation will assess the effectiveness, accessibility and cost-effectiveness of the three services in comparison with six traditional services. A broad range of stakeholders, including service users, are involved in the evaluation.

In terms of the wider context of network development, the National Strategy for Sexual Health and HIV states that:

- new standards will be set to change the constraints of narrow, non-integrated service provision
- there will be a process for developing networks in sexual health services

We therefore commissioned the Medical Foundation for AIDS & Sexual Health (MedFASH) to take forward this work by:

(a) developing overarching recommended standards for sexual health services, which will signpost and complement the range of existing guidance for different aspects of sexual health service provision. Reflecting the content of the national strategy, the project's scope covers contraception, sexually transmitted infections, abortion, access to psychosexual services, and sexual health promotion. The standards were published on 16 March this year and are relevant for all settings where sexual health need may be identified or addressed, including primary care and specialist services.

(b) facilitating the development of sexual health service networks, through disseminating knowledge and learning about networks, and useful examples of practice. This work is still ongoing.

The project builds on recent work by MedFASH on standards and network development for NHS HIV services.

- 16. We are pleased that the Government has accepted our recommendation to conduct an audit of contraceptive services, with attached funding to rectify any problems, and that this audit will include GP contraceptive provision. We look forward to receiving the results in due course. We recommend that the Department, in its review of the GP contract, consider introducing incentives for GPs to deliver higher quality contraceptive services. (Paragraph 74)**

The review of the GMS contract is underway and many proposals for inclusion into the Quality Outcomes Framework (QOF) have been submitted. There are 6 sexual health submissions, largely compiled in accordance with the report from the Health Select Committee inquiry, paying special attention to the issues raised in the report around primary care. The QOF Teams and Primary Medical Care Contracting (PMCC) recognise that sexual health is a priority for improved delivery in primary care. Currently, the negotiating mandate for NHS Employers has not yet been finally agreed, and sexual health is certainly being carefully considered. (See also recommendation 12 above).

As part of further strengthening the involvement of primary care in sexual health services, from 2006/07 the Healthcare Commission have agreed to consider inclusion of a number of indicators. This will include consideration of an indicator to look at GP prescribing activity levels for contraceptives

- 17. We are surprised that although the White Paper devotes an entire section to sexual health, it does not discuss abortion services. They are an important aspect of sexual health services, as the Government's 2001 Strategy acknowledged. It is crucial that the Government retains the *National Strategy for Sexual Health and HIV's* target that from 2005 commissioners should ensure that women have access to abortion within three weeks of the first appointment with the GP or other referring doctor. The Healthcare Commission should also retain its PCT performance indicator of the percentage of NHS-funded abortions performed under 10 weeks. (Paragraph 77)**

The White Paper covers sexual health as a whole, with an emphasis on prevention. We are working to reduce the number of abortions by helping PCTs to improve access to contraception services and to the wide range of contraception available. We agree it is important that women who seek an abortion are seen quickly and the standard in the National Strategy for Sexual Health and HIV, that women should have access to abortion within three weeks of the first appointment with the GP or other referring doctor, still stands – the Strategy is a 10 year plan. We have invested £6 million over the last three years to help PCTs work towards this standard. This year will be the third year that PCTs have been rated against their performance on the percentage of NHS-funded abortions performed under 10 weeks gestation. This indicator has had an effect in increasing the percentage of abortions performed earlier and we are aware of abortion services being reorganised to minimise delays in access. It is however a matter for the Healthcare Commission as to what measures are used to monitor NHS performance in future years.

Sex and relationships education

- 18. We welcome the acknowledgement by the Department for Education and Skills that Personal Social and Health Education (PSHE) and Sex and Relationships Education (SRE) lessons are far better taught by specialist teachers than by form tutors, and are pleased that increasing numbers of teachers are completing specialist training to becoming accredited PSHE teachers. However, we remain deeply concerned that, by DfES's own admission, in the majority of schools PSHE and SRE lessons are taught by form tutors rather than by specialist teachers. We therefore recommend that the DfES issue specific guidance to schools stipulating that by 2007 all PSHE and SRE lessons must be taught by specialist accredited PSHE teachers rather than by unqualified form tutors. These teachers should build up and maintain links with clinicians working in sexual health, including community nurses and GPs, who can often contribute very usefully to SRE but who should not be used as a substitute for a qualified SRE teacher. (Paragraph 86)**

The Government is committed to improving the quality of teaching in PSHE and ensuring teachers are able to access high quality continuing professional development (CPD) opportunities in PSHE. This is one of the reasons why PSHE is a critical and core component of the new Healthy Schools definition. The Government expects half of all schools to be Healthy Schools by 2006 with the rest working towards Healthy Schools status by 2009. This should have a significant impact on the quality of teaching of PSHE in schools.

The PSHE CPD certificate for teachers has been developed and promoted by DfES and will benefit over 4000 teachers by 2006. The Department is examining how the certificate can be made available thereafter. We are encouraging take up of the certificate through local healthy schools programme leads. We have also produced the PSHE into Practice resource for teachers in both primary and secondary schools. We continue to review how we can improve the quality of PSHE teaching. DfES does not plan to issue guidance as recommended by the Committee but will continue to disseminate the messages about the benefits of specialist teams as set out in the Ofsted PSHE report wherever possible. We have asked the National Children's Bureau to scope possible options for a PSHE subject association and the extent to which an association can support teachers of PSHE. We recognise that improving young people's sexual health has to be based on partnership working between those professionals working with young people. As part of the PSHE certificate, teachers are asked to provide evidence of effective partnerships with other professionals. The move towards children's trusts, extended schools and multi agency working will ensure there is closer cooperation between teachers and other professionals.

- 19. We are disappointed that, despite a report from its own schools inspectorate stating that a major weakness of PSHE is its current lack of assessment, and the fact that it is often afforded insufficient time and priority within the school curriculum, DfES is unwilling to make PSHE and SRE a statutory part of the National Curriculum. The costs and consequences of this ill considered decision are considerable. We again recommend the establishment of PSHE and SRE as statutory and assessed parts of the National Curriculum. (Paragraph 89)**

Sex and relationship education is a statutory part of the curriculum. All pupils must learn about human reproduction and fertilisation, the physical and emotional changes through adolescence and about HIV/AIDS and STIs. PSHE is a non-statutory framework through which both statutory, for example sex education and drug education, and non-statutory themes can be taught. As part of a review of the Key Stage 3 curriculum, we have asked the Qualifications and Curriculum Authority (QCA) to look at the content of PSHE and its relationship with Citizenship education. We will need to consider the outcome of this review before making any further decisions on any changes to PSHE. The Government's priority is to support teachers to deliver better quality PSHE provision in schools. DfES has recognised that assessment in PSHE remains an issue for many schools. That is why we are working with the QCA to develop a package of guidance to support the teaching of PSHE, including end of key stage statements which will help teachers assess pupil progress in PSHE.

CHARGES FOR OVERSEAS VISITORS FOR HIV/AIDS TREATMENT

- 20. It is very important that the UK does not become a magnet for HIV+ individuals seeking to emigrate to this country solely to access free healthcare. However, neither the Department nor any other interested parties have been able to present us with any evidence suggesting that that this is currently the case, or that the introduction of these restrictions on free treatment will actively discourage people from entering or remaining in this country illegally. What little evidence exists in this area in fact seems to suggest that HIV tourism is not taking place. It suggests that HIV+ migrants do not access NHS services until their disease is very advanced, usually many months or even years after their arrival in the UK, which would not be the expected behaviour of a cynical “health tourist” who had come to this country solely to access free services. (Paragraph 111)**

It is encouraging that the Select Committee recognises that the Government has an important responsibility to ensure that opportunities for abuse of the NHS by overseas visitors not entitled to use it free of charge are kept to an absolute minimum. That was the fundamental objective of all the changes made to the charging regulations last April. Whilst it is true that the policy of successive Governments not to burden the NHS with a requirement to collect data on the numbers of overseas visitors treated etc means that it is impossible to provide the sort of definitive statistics the Select Committee would apparently like to see, the Government does not accept the argument that this means there is no evidence that abuse of the NHS is taking place. The Committee has apparently placed considerable weight on the examples provided by the Terrence Higgins Trust (THT) and National AIDS Trust (NAT) in their evidence. In the same way, when conducting its review of the operation of the charging regime which led to the changes last April, the Government has placed similar weight on the many, many examples given to it by Overseas Visitors Managers of overseas visitors who approach the NHS every day seeking to abuse its services.

There are also some important points about the survey results offered in evidence by the THT which the Committee do not appear to have considered. Whilst the 60 persons included in the survey were identified as migrants, it is not clear whether they would in fact have been chargeable, or whether they had come to the UK and were engaged in activities which made them either exempt from charges or ordinarily resident. Without that additional contextual information, the usefulness of the survey does seem somewhat diminished.

The evidence from Overseas Visitors Managers generally suggests that individuals seeking to abuse the NHS wait until they are seriously ill before arriving in an Accident and Emergency Department in this country, sometimes straight from the airport, needing immediately necessary treatment which is, of course, provided. It is precisely because that kind of immediate access is available that the UK is a popular destination – people out to abuse the system do not seem to wait for weeks or months before seeking out services, they do it as soon as possible after they get here. The secrecy around HIV treatment, described in the Committee's report, means that Overseas Visitors Managers may never get to hear about these cases, so cannot follow them up. Moreover, it is possible that people receiving HIV treatment to which they know they are not entitled will not seek out the services of organisations like the Terrence Higgins Trust who receive significant government funding.

The Government remains convinced that deliberate abuse of the NHS by overseas visitors, across a range of services, is not just a potential threat but a very real one and the Government must fulfil its responsibility to ensure that the NHS is protected for those who are entitled to receive it free of charge. That applies as much to HIV treatment as to any other hospital service.

- 21. We have received evidence that NHS staff are finding it very hard to implement the new regulations in so far as they affect HIV patients. Because of the highly confidential basis on which they are run, sexual health and HIV services may be reluctant to give overseas patient managers access to their patients, meaning that the difficult job of determining eligibility falls to doctors or receptionists. Receptionists are unqualified to make the clinical decisions that may be necessary to determine whether a person needs free treatment; and doctors, when required to adopt a "gatekeeper" role in determining a patient's eligibility for free treatment, feel an irreconcilable conflict with their primary duty to care for the patient. (Paragraph 120)**

The Government agrees entirely that it is not the job of clinicians to implement the overseas charging regime. The key to avoiding this is proper collaboration with the trust's Overseas Visitors Manager. Whether a patient accesses hospital services through Accident and Emergency, or a walk-in clinic or by GP referral, receptionists, ward clerks and other administrative staff responsible for booking the patient in will ask certain questions, which can and should include the baseline residency questions identified in the Department of Health's guidance on implementing the charging regime. The responses to those questions may trigger a referral to the Overseas Visitors Manager, who has the experience and expertise to conduct more detailed investigations of the patient's eligibility. In non-urgent cases, this can happen before treatment begins, so that the patient knows where they stand from the outset. Where treatment is immediately necessary, it will be given immediately, and the investigations as to eligibility may have to wait until the patient is well enough to answer questions. There is no reason why this sort of arrangement cannot be extended to HIV clinics. Overseas Visitors Managers are bound by the same duty of confidentiality as all other NHS staff, so patients are not at any risk, and consultants can concentrate on their task of treating patients. Going through the process can confirm their eligibility, and it is important to remember that the questions they would be asked are only those which they should always have been asked but which in the past may not have been.

- 22. During oral evidence the Minister answered almost all of our arguments by repeating that, although HIV treatment is no longer free for people living in this country without proper authority, "there is still provision for easement by individual clinicians under individual circumstances, and at the end of the day, the decisions are the clinician's". We have not seen any evidence to suggest that the Department intended the clause for "immediately necessary" treatment to allow clinicians to provide free routine HIV care to all HIV+ patients, regardless of eligibility, and nor does our evidence suggest that clinicians and Trusts are interpreting the regulations in this way. If it is the Department's intention that the regulations be interpreted this way, we recommend that it issues guidance to this effect immediately. However, we do not believe that the Department does intend the regulations to be interpreted in this way. Rather, it seems that regarding HIV, this easement clause provides clinicians with only very limited flexibility to provide treatment for ineligible HIV+ patients once they become severely unwell or their immune system is significantly weakened, rather than enabling them to prevent this deterioration in the first place (Paragraph 125)**

Regrettably there has been some confusion about what the Minister was discussing when she spoke about the “easement clause” during her oral evidence. She did endeavour to put this right in her subsequent letter to the Committee of 28th February 2005. The arrangements the Minister was referring to were described in paragraph 11 of the Department of Health’s written evidence to the Select Committee. The easement comes in the fact that anyone who has already begun treatment, including HIV treatment, on the understanding that they are entitled to receive it free of charge must continue to receive that course of treatment free until it is completed, or they leave the country or are deported. This applies even if it is established that they are no longer eligible for free treatment or, indeed, that they never were eligible. This means that there is absolutely no question of, for example, an asylum seeker who has begun a course of HIV treatment, suddenly being asked to pay for it to continue because their asylum application has been turned down. The key point being made by the Minister was that where a clinician had decided a particular course of treatment was appropriate, the easement clause guaranteed that this decision remained paramount if the patient’s eligibility status changed.

This is clearly something very different from the issue of whether treatment is immediately necessary, and the Minister certainly did not intend to give the impression that the Government was suggesting that clinicians should use its guidance on immediately necessary treatment as a means of providing free treatment to patients who would otherwise be subject to charges.

- 23. The Department’s consultation on changes to charging rules for overseas visitors suggested that cost-saving was a key reason for reviewing the regulations. We were therefore astonished that, by the Department’s own admission, these changes have been introduced without any attempt at a cost-benefit analysis, and without the Department having even a rough idea of the numbers of individuals that are likely to be affected. While generating even small amounts of savings for the NHS might appear to be worthwhile, in the case of HIV treatment we have received powerful evidence that it would in fact be more cost-effective to provide free HIV treatment to all, as, without treatment, HIV+ individuals living in this country without proper authority are likely to place a far greater burden on NHS resources. We recommend that the Department reviews the financial implications of this policy immediately and, furthermore, that it ensures all its future policy decisions are based on evidence and underpinned by robust cost-benefit analyses, as stipulated by Cabinet Office and Treasury guidelines. (Paragraph 138)**

See below.

- 24. In its cost-benefit analysis of the changes to regulations governing access to free NHS treatment for overseas visitors, the Department must also take into account the potential costs associated with increased onward transmission of HIV. (Paragraph 139)**

The consultation document on changes to the hospital charging regulations⁵ said that the aim of the proposed revisions was:

- To bring the Regulations in line with today's more global society; to protect finite NHS resources by closing up loopholes where it has been identified that certain regulations may be open to abuse; and to provide greater clarity to enable NHS trusts to apply them more efficiently. (para. 3.4)

Thus, whilst protection of NHS resources was certainly one objective, it was by no means the only one. Equally important was, and is, the protection of the principle that the NHS exists primarily for the benefit of those who are living legally in the UK, and not for those who are not. Where that is concerned, as John Hutton pointed out when announcing the outcome of the consultation in December 2003, the key issue is that the Government must fulfil its responsibility to preserve the NHS for those who are entitled to use it free of charge by reducing the opportunities for abuse to a minimum, irrespective of the actual cost of that abuse.

The fact is that, whilst the Committee has chosen to take a very narrow view of the charging arrangements only as they relate to HIV treatment, as they are of course entitled to do, the Government must take a wider perspective, looking at the NHS as a whole, and at more than just monetary issues. It remains convinced that the charging regime, and the changes to it introduced last year, represent the correct approach to balance public health responsibilities, and responsibilities to individual patients, with the Government's wider responsibilities in terms of immigration and asylum policy. These are questions about what is right and necessary that cannot be assessed through a cost-benefit analysis.

- 25. We were surprised to learn that no public health impact analysis of these regulations was carried out prior to their enactment, particularly given the level of the public health threat posed by HIV and the increasing rates now being seen in this country. We are aware that public health arguments were put to the Department during its consultation, but these arguments do not appear to have been answered or taken account of. Given the Department's responsibility for safeguarding public health this seems short-sighted, and suggests a lack of coherence within policy making within the Department. We recommend that, in addition to cost-benefit analyses, public health impact analyses be carried out in respect of all Department of Health policies. (Paragraph 145)**

⁵ *Proposed Amendments to the National Health Service (Charges to Overseas Visitors) Regulations 1989: A Consultation*, Department of Health, July 2003

On the contrary, the easement clause discussed above was introduced into the revised regulations specifically in response to some of the public health arguments raised by clinicians about the inappropriateness of risking treatment being effectively stopped part-way through because someone's eligibility status changes and they are unable to pay. Moreover, the commitment to always provide immediately necessary treatment provides another safeguard, since it is always a clinical decision, never administrative, as to whether treatment is immediately necessary. Nevertheless, a balance has to be struck between the Government's public health responsibilities and those of ensuring that the NHS is no longer seen as a global health service, again looking at a somewhat wider picture than just that of HIV treatment provision. The Government believes that a fair balance has been achieved, because it cannot be right deliberately to provide encouragement to people who are here illegally to remain because they can expect to receive free NHS hospital treatment.

- 26. We are unable to share the Minister's optimistic view that the introduction of charges will have no impact on the numbers of people coming forward for HIV testing. Although charges have been in place for less than a year, the fact that organisations such as the Terrence Higgins Trust are already reporting a growing reluctance to have HIV tests amongst migrant communities is extremely worrying. (Paragraph 151)**

See below.

- 27. Coupled with increasing confusion regarding eligibility for HIV treatment even amongst those who are eligible, and fear amongst migrant communities that if, in future, they attend health services they will be questioned about their immigration status, this strongly suggests that the introduction of charges for HIV treatment will increase the number of HIV+ people living in this country who are unaware of their infection, in direct contradiction of the Government's target to reduce the number of undiagnosed HIV infections. An increase in the numbers of people who are unaware of their HIV+ status will pose a serious and escalating threat to public health. (Paragraph 152)**

Data from the Health Protection Agency (HPA) on the uptake of HIV testing and prevalence data (including undiagnosed HIV) is not yet available for 2004 when the amended Regulations took effect. The HPA will include this data as part of their 2004 annual report due in November this year. However, consultants at two large London HIV treatment centres have told the Department of Health that they have seen no evidence that the application of the amended NHS Charging Regulations is leading to individuals being refused HIV treatment. When questioned about their eligibility status, most are found to be eligible either because they are ordinarily resident here, or exempt from charges.

It is unfortunate that the Select Committee seems to have fallen into the same error as many others in believing that the changes made last year amounted to the “introduction of charges” for HIV treatment. The Government would reiterate again that the treatment of HIV has never been free to chargeable overseas visitors since the first introduction of a charging regime. What changed last year was that people who are here illegally, for whatever reason, stopped being able to abuse the hospitality of the UK by getting free hospital treatment to which they were not entitled simply by managing to stay here for a year. This is a vitally important point. The only people who have anything to fear from that change are those who are abusing the system and shouldn’t be here. The fact that they have managed to stay here for a long period of time simply cannot be allowed to be an excuse for getting free treatment without question. Those who came here entirely legitimately, such as asylum seekers, are protected by the easement clause – their HIV treatment isn’t going to stop being free of charge if their claim fails so there is absolutely no reason for them not to come forward for testing.

- 28. The evidence refutes the Minister’s stance that anti-retroviral treatment does not reduce HIV infectivity and therefore has no impact on public health. On the contrary, the scientific literature to date suggests that HIV infectivity is directly linked to viral load, and therefore that treatment which reduces the viral load of HIV+ individuals will potentially reduce onward transmission of HIV. Indeed, the Health Protection Agency, the Government’s own public health advisory body, stated unequivocally to us that “if you do not treat individuals and they remain in this country and are sexually active in this country, then the transmission is bound to go up.” (Paragraph 161)**

See below.

- 29. While we accept that, in giving evidence to us, the Public Health Minister was not supported by a Department of Health official with medical expertise, we are surprised that she appeared so unbriefed on basic aspects of public health prevention. Firstly, many treatments do not reduce the risk of onward transmission to zero. This is the case for genital herpes and for TB, both of which are exempt from treatment charges on public health grounds. Secondly, it is worthwhile reducing the risk of onward transmission of a disease, even if it cannot be eliminated. (Paragraph 162)**

The Minister did not say that anti-retroviral treatment does not reduce HIV infectivity. Her argument was that, unlike TB and the vast majority of conditions specified as exempt from charges within the charging regulations, there is still no cure for HIV. That is one of the reasons why TB treatment is free to all. Also the transmission routes for TB and HIV are very different. For HIV, however, it is as important in public health terms to ensure that people are aware of their status so they can take greater care of their health and be supported to change their behaviour to reduce the risk of transmission to others. That is why diagnostic testing for HIV and associated counselling is free to all. That in itself contributes to reducing the risk of onward transmission.

- 30. We welcome the Department's statement that hospital maternity services should always be considered immediately necessary treatment, including, where necessary, HIV treatment. However, evidence presented to us suggests that considerable confusion exists over eligibility for maternity services. If the charging regulations are extended to encompass GP services, this situation is likely to worsen, as primary care is a key access point for ante-natal services. We recommend that the Department immediately issue further guidance to the NHS stating that antenatal and maternity services, including HIV treatment to prevent mother-to-child transmission, must be made available to all women, regardless of their immigration status or ability to fund the treatment. (Paragraph 166)**

The Government acknowledges that, despite the fact that the guidance on how to deal with pregnant overseas visitors is both explicit and long-standing, there does seem to be some uncertainty within the NHS on how to respond to such cases. The guidance was therefore reissued on 16 May.

- 31. We are extremely alarmed by the prospect of people co-infected with HIV and TB being managed ineffectively. If their underlying HIV is not treated because of cost, they may then default from care and as a consequence transmit TB to as many as 15 people a year. It is a nonsense that the Government is prepared to fund a person's TB treatment on public health grounds but not treatment of his HIV infection. (Paragraph 171)**

As previously explained, the Government's view is that the public health risks associated with TB are very different from those of HIV. TB for example, is airborne but HIV is not. Moreover not everyone is co-infected, and the Government takes the view that the co-infection argument is not of itself sufficient justification for making HIV treatment free to all.

- 32. Primary care can be a vital access point for all types of services. This includes services which the Government stipulates must continue to be provided free to all people, regardless of their eligibility status, such as HIV testing, treatment for communicable diseases such as TB, antenatal and maternity services, and "immediately necessary" treatment for emergency problems. Refusing patients free access to GP services could, arguably, be seen to undermine all these exemptions that the Government has made within the charging regime by denying patients access to a first, basic health assessment. We therefore recommend that all people, regardless of their eligibility status, are given access to a free primary care health assessment. (Paragraph 174)**

The Government is still considering the outcome of the consultation on access to primary medical services for overseas visitors. However, the consultation document made clear that, as far as practicable, the same range of exemptions would be maintained in primary medical services as in hospital services in any charging arrangements that may be adopted. Nevertheless, the Committee's recommendation will be taken into account during the decision-making process.

33. We are deeply concerned that neither the Department nor the Public Health Minister appear to have considered or understood the public health implications of refusing HIV treatment to people who, although not legally resident, continue to live in this country. Firstly, it seems that this policy is already deterring people in high-prevalence migrant communities from accessing HIV testing. Equally importantly, by denying people free HIV treatment, a vital opportunity is being missed to reduce by perhaps as much as 60% their likelihood of transmitting HIV within the wider resident population. We dispute the Minister's view that HIV treatment benefits only the person receiving it, and her view that for a public health intervention to be worthwhile it must reduce the risk of onward transmission to zero – TB and genital herpes are just two examples of communicable diseases for which treatment is currently free where a significant risk of recurrence and onward transmission remains despite a course of treatment. We also have serious concerns about the impact of this policy on mother-to-child transmission of HIV, and of the onward transmission of TB, including drug-resistant strains. (Paragraph 175)

See below.

34. During our evidence session, the Minister mentioned the "easement clause" the Government has introduced, which enables clinicians to provide treatment deemed to be "immediately necessary" regardless of a person's eligibility status. In a subsequent letter she also further emphasised the clause which states that where a person has begun a course of free NHS treatment, that treatment will continue to be free until the course of treatment has been completed. According to the Minister, "for HIV in many cases this will mean treatment will continue free of charge for a very long time". While we appreciate these attempts on the Government's part to reduce the impact of the regulations on those who have life-threatening problems or who have already begun treatment, we feel that they do not adequately address the problems that we have identified in respect of HIV. (Paragraph 176)

See below.

35. We agree with the Minister that it is appropriate to provide a national health service, not a global one. However, a crucial part of the Government's responsibility to provide a national health service is to protect the health of the population. Untreated HIV+ people living in this country present a serious public health threat, and we therefore recommend that all HIV+ people, regardless of their immigration status, receive free treatment to reduce the likelihood of the onward transmission of HIV, of mother-to-child transmission of HIV, and of the onward transmission of TB. We believe that to achieve this, HIV should be reclassified as a Sexually Transmitted Infection, which would make treatment automatically free on public health grounds. If, subsequently, there is evidence that as a result of this decision the UK is becoming a magnet for HIV+ people around the world seeking access to free treatment, which from the evidence we have heard we do not anticipate, the policy can be reviewed. (Paragraph 177)

When the Select Committee published its report John Hutton MP made clear that the NHS is not a free service for illegal immigrants or failed asylum seekers, or others with no legal right to be living here. The Government does not accept that such persons with HIV should receive free treatment without question. As previously explained, the NHS has always had powers to charge for these services, all we have done is make it more difficult for people who should not be receiving them free of charge to take advantage of the system.

It is certainly not the case that no thought has been given to the public health implications. On the contrary, certain measures, such as the easement clause, have been brought in specifically to respond to those issues. But the Government must balance that against the equally important issue of not creating an incentive for increased illegal immigration, or contributing to encouraging those who are already here illegally to remain. The Government remains entirely convinced that the balance is correct.



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